

Voiced but unheard agendas: qualitative analysis of the psychosocial cues that patients with unexplained symptoms present to general practitioners

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SUMMARY

Background: Symptomatic investigation and treatment of unexplained physical symptoms is often attributed to patients' beliefs and demands for physical treatments.

Aim: To test the influential assumption that patients who present symptoms that the general practitioner (GP) considers to be medically unexplained do not generally provide the opportunity for discussion of psychological issues.

Design of study: Qualitative analysis of audiotaped consultations between patients and GPs.

Setting: Seven general practices in Merseyside, United Kingdom.

Methods: Transcripts of audiotaped consultations between 21 GPs and 36 patients with medically unexplained symptoms were analysed inductively to identify opportunities that patients presented for their doctors to address emotional problems or their need for explanation.

Results: All but two patients provided psychological opportunities. They described social or emotional difficulties as problems of stress or mood. They presented their need for explanation by: explicit questions; statements of concern about symptoms; suggestions that disease might be absent; or tentative references to serious disease. In general, GPs did not engage with these cues.

Conclusions: Patients with unexplained symptoms present opportunities for GPs to address psychological needs. By taking these opportunities, GPs might be able to avoid unnecessary symptomatic intervention.

Keywords: consultation; general practice; psychosocial outcomes; unexplained symptoms.

Introduction

NEARLY a fifth of adults who attend a general practitioner (GP) with persistent physical symptoms are thought by the doctor to have no physical disease.¹ Nevertheless, many receive symptomatic treatment, investigation and referral. This is often attributed to patients' beliefs that their symptoms are physically based and to their consequent insistence on symptomatic intervention as an alternative to considering psychological issues.^{2,3} Therefore, attempts to improve care have emphasised the need for doctors to help these patients think psychologically about their problems.⁴ However, the assumption that these patients exclude psychological issues has not been tested.

Two sets of psychological factors, corresponding to needs for 'cognitive' and 'emotional' care,⁵ respectively, might explain why some patients consult with unexplained symptoms. First, many fear serious disease or are puzzled about what causes their symptoms.⁶ Therefore, like primary care patients in general, they seek effective explanation from the GP. Second, although emotional disorder is not ubiquitous in these patients and, where it does occur, it might be secondary to the symptoms, there is a long-standing view that unexplained symptoms indicate emotional problems and needs.⁷

As part of a study of how GPs and patients negotiate treatment of medically unexplained symptoms, we have scrutinised transcripts of consultations with patients presenting such symptoms. This showed a need to re-examine the assumption that many patients exclude psychological issues. We therefore systematically analysed these transcripts to find out: whether patients present psychological cues; what kinds of cues they present; and how GPs respond to them.

Method

Sample

GPs from seven practices were invited by letter to take part. The research was explained to them as a study of doctor-patient communication focusing on patients' presentation of symptoms when pathology is absent. Of 30 doctors contacted, 28 agreed to participate: 15 were male, 13 female, with primary care experience of 5–42 years (mean = 18 years). Practices included urban ($n = 3$), suburban ($n = 3$) and rural locations ($n = 1$), with practice size ranging from 2180 to 13 116 patients (mean size = 8284 patients) and from 1 to 10 GPs (median = 5 GPs). Jarman scores for these practices ranged from -11 to 38 (mean = 17.6), indicating levels of deprivation higher than the average for England.

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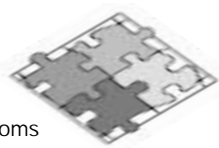
HOW THIS FITS IN

What do we know?

Patients presenting with physical symptoms unexplained by physical disease are common in primary care. It is generally assumed that they seek to exclude psychological needs from consultation and insist on symptomatic responses from the general practitioner (GP).

What does this paper add?

Almost all patients provided opportunities for the GP to address their need for explanation of their symptoms or to have emotional or social problems addressed. GPs tended to disregard these opportunities.



There are no agreed research diagnostic criteria for primary care patients with unexplained physical symptoms. Criteria derived from psychiatric diagnoses of somatisation disorder are problematic because of poor agreement among them or poor discriminating capacity compared to psychiatric interview.^{8,9} A common procedure for studies in the United Kingdom is to select from patients with symptoms designated by the GP as unexplained, those who are psychologically disturbed and who respond to a single question by attributing their symptoms to a physical, rather than psychological, cause.¹⁰ This procedure restricts concern to those who manifest psychological disturbance on a screening questionnaire and assumes that patients readily distinguish physical from psychological causes. Because our study was focused on the difficulties that patients present for GPs, we used less restrictive criteria that are strongly associated with diagnostic criteria for abridged somatisation disorder and identify those patients that the GP considers have unexplained symptoms.¹ Immediately after consultation, the GP completed a checklist to indicate whether the consultation met four criteria: (a) the presentation of a physical symptom; (b) the symptom had existed for at least 3 months; (c) it had caused clinically significant distress or impairment; and (d) it could not be explained by physical disease. Consultations meeting all criteria were retained for analysis. These criteria can be readily understood and applied by GPs, and allow for the variation between them in decisions about which symptoms are unexplained. Although it is possible that some symptoms identified as 'unexplained' might prove to have a pathological cause, our procedure ensures a patient group that is defined by their clinicians' belief that such a cause is absent.

Procedure

Consecutive patients ($n = 659$) attending designated GPs on study days were approached by the female researcher before consultation and asked for written consent to participate in a study of 'doctor-patient communication'; 110 were excluded (aged <16 years, inability to consent because of visual impairment, learning disability or extreme distress); 426 consented. Each doctor operated a desktop microphone to record consultations with consenting patients (23 consultations were not recorded because of equipment

failure or operator error). GPs completed the checklist (see above) immediately after each consultation, yielding 41 consultations that were were anonymously transcribed; five were then discarded because of insufficient discussion of physical symptoms.

Analysis

Analysis was inductive. Initial reading and discussion of the first 10 transcripts by all authors identified the need to question the assumption that psychological cues would be minimal. Preliminary analysis of such cues was led by one author and developed and tested by inclusion of subsequent transcripts, which were read and discussed by all authors. Analysis focused exclusively on verbal content in identifying recurring ways of presenting and responding to psychological cues; it excluded non-verbal or contextual factors and avoided imputations of participants' motives. Psychological cues were recognised where patients disclosed emotional or social problems, or indicated a need for explanation. Their common link was functional, in that they afforded GPs an opportunity to address psychological perspectives on the presented problems.¹¹ Significant types of opportunity were defined by commonalities between two or more consultations. Examples are given below to illustrate the range and commonality within each type of opportunity and response.

Cycling between data and the developing analysis, the use of authors from different disciplinary backgrounds in different roles, and presentation of relevant transcripts are procedural sources of trustworthiness of qualitative analyses.¹² Procedures are, however, insufficient to guarantee trustworthy findings.¹³ Additional criteria by which we assessed the findings included their coherence¹² and 'catalytic validity',¹⁴ whereby the analysis should not merely describe, but should have the potential to change, clinical practice or research. Counts of themes that emerge from qualitative analysis can help to assess the completeness of the analysis.¹⁵ Therefore, for each type of opportunity, we counted the number of consultations in which we detected it.

Results

Sample characteristics

The transcript sample involved 21 GPs (nine female) and 36 patients (26 female) aged from 19–81 years (mean age = 49 years). All but two patients were white European. The most common symptoms were abdominal complaints ($n = 10$), pain in limbs ($n = 9$) or headaches ($n = 7$), others including chest pain, back pain, dizziness, fatigue, skin problems and gynaecological or genitourinary symptoms (Supplementary information Appendix 1). Patients presented between one and seven symptoms, of which least one had lasted (either persistently or intermittently) for 3 months or longer. The consultations led to a range of somatic outcomes including 27 somatic prescriptions, 12 sets of investigations, five referrals and five sick notes. Five patients were prescribed psychotropic drugs.

Types of opportunity and response are summarised in Table 1. All but two patients provided at least one opportunity, and most provided many opportunities of different types.

Table 1. The types of psychological opportunity that patients presented, and the ways that GPs responded to them.

Opportunity	Patients' mode of presentation	GPs' responses
Explanation	<ul style="list-style-type: none"> • Explicit request • State uncertainty or worry • Propose serious illness • Propose normalising explanations 	<ul style="list-style-type: none"> • Ignore • Reassure • Offer tests, treatment or referral
Address emotional or social problems	<ul style="list-style-type: none"> • Life stress • Mood and depression • Somatic metaphors of mood 	<ul style="list-style-type: none"> • Ignore • Assert somatic or business agenda • Normalise • Place responsibility with patient • Closed questions • Counsel

Opportunities for explanation

Most patients ($n = 27$) offered cues for explanation. Seven asked explicitly; for example, 'What do you think's causing it?' More commonly ($n = 18$), patients were less direct and merely stated their own uncertainty. Indeed, the phrase 'I don't know' occurred in this context in nine consultations; for example, 'I don't know whether it's anything or nothing'. Patients also indicated anxiety about not knowing what was wrong; eight referred to being worried or even scared, often in response to negative results of investigations:

Dr: 'OK. So, you know, you have been checked over.'

Patient (P): 'Which is a worry.'

Most patients mentioned explanations for their symptoms and, for 15 patients, these explicitly stated disease, including cancer, or implied disease by reference to body parts; for example, 'a bit of pain under the heart'. However, nearly as many cues ($n = 14$) excluded serious disease by proposing normalising explanations such as, 'wind', 'I've pulled a muscle', 'stress' or by suggesting that, 'it might go away' or that, 'it would be nice to find out ... if ... I've got to live with it'. Explanations were not asserted. Instead, patients offered evidence for them, particularly family history:

'The more reason I'm scared than anything is two of my aunties, two of my uncles and my gran had all died of lung cancer which all started with a lump in my [sic] neck and I know mine probably isn't that and I'm over-reacting.'

Patients also reported evidence from lay consultations, which were sometimes used to evaluate specialist advice:

'I mean [hospital doctors] thought it might have been my gall bladder. Then I've spoken to different people and they said, well it could be coming from somewhere, stemming from somewhere else.'

Patients also sought evidence to link symptoms with their lifestyle:

'Now I'm trying to sort of think of what sets it off; and one proposed that I might be best to try and keep some kind of diary of when I get them [headaches].'

GPs' responses to opportunities for explanation

Most opportunities were disregarded. Where GPs responded, they typically offered reassurance or benign explanation that did not engage with the patients' stated concerns:

P: 'That's really my main worry cos I have heard of IBS.'

Dr: 'You see the reassuring thing is you have had it for quite a while now and you haven't actually developed anything with it.'

Alternatively, they reasserted a somatic agenda:

P: 'It just, what's going wrong with my mind, you know?'

Dr: 'I don't think there's anything serious going wrong. Do you need any tablets?'

Other responses concurred with the patients' concerns.

P: 'Is it likely to be an ulcer?'

Dr: 'It's not impossible. At your age we wouldn't really stick a tube down and have a look at your stomach. I think it's very much take the tablets.'

Cues also elicited tests, treatment or referral. However, these did not reliably conclude the patient's presentation:

P: 'What do you think's causing it?'

Dr: 'Well I can't see anything sinister lying around, you know there's dry in the right one [ear] and left one's fine but you never get a very good view trying to look down the inside of a tube. I would try the olive oil and just see if that helps. If it makes no difference whatsoever come back to us and we'll have another think.'

P: 'But I just don't know, but all of a sudden they're really, really. Honest to God it's a nightmare sometimes.'

Occasionally, reassurance was contradicted by juxtaposition with referral 'just to be on the safe side' or with the suggestion that, as in the above example, treatment would fail and therefore prompt 'another think'. We observed only one instance in which a doctor engaged with a

patient's explanatory model by providing specific evidence against it.

Opportunities to address emotional and social problems

Most patients ($n = 23$) provided explicit cues about emotional or social problems. More than half of these ($n = 14$) described life events, domestic or employment problems, and seven of these explicitly cited stress. A similar number ($n = 13$) reported emotional problems such as mood swings, crying, or being bad tempered or lonely, including six who explicitly cited depression. Several of these patients, as well as two others who provided no explicit emotional cues, used physical terms that are emotional metaphors, such as 'lack of energy' or 'feeling shattered'.

Six patients provided these cues as part of their initial presentation. Six others were successfully prompted to disclose emotional or social problems against a background of somatically focused dialogue later in consultation — although prompts about life stress or tension were more successful than questions about mood:

Dr: 'No discharges or anything like that?'

P: 'Occasionally I do. It's like a yellowy colour. It smells. It's only been recently.'

[Omitted doctor and patient speech.]

P: 'I feel I can smell it all the time and I think if I can smell it, everybody else can smell it.'

Dr: 'So you're worried that ...'

P: 'That everyone else can.'

Dr: 'Do you feel depressed in any other way?'

P: 'No, I did last time I came to see you but I've recently had discussions with my husband, and things are a lot better now ... I feel a lot better plus the fact life's going the right way at the moment, starting to open a new business.'

[Omitted doctor and patient speech during which the patient mentions having had headache symptoms.]

Dr: 'Sounds like a tension headache.'

P: 'Probably is, I've got a lot going on at the moment.'

Mostly, however, patients ($n = 13$) interjected psychosocial cues after symptomatically focused dialogue; for example:

Dr: 'If it doesn't clear up I'm going to want to look into it myself, even though the chest X-ray is clear. So we'll give it a fortnight. You shouldn't have a persistent symptom, should you?'

P: 'No. When I went to the hospital it lasted for about 3 or 4 days and then it eased off but it's just started now when

I wake up. I just feel, I've been a bit down. I sit there and I have a little cry. I'm worried about myself and I'm also worried about the wife you know ... all this just seems to be just coming on me, just sit there and have a little cry and I'm alright then. It's been happening the last week or so. I think everything's just getting on top of me.'

Psychosocial cues were also provided when the GP's symptomatic response to symptoms threatened to close the consultation:

Dr: 'Do you fancy having an ECG for us on Monday here?'

P: 'ECG alright then, yes, I don't mind. I just want to feel right and get my life sorted out and change.'

GPs' responses to psychosocial opportunities

Responses divided into those that blocked or facilitated psychosocial discussion. Blocking was achieved by disregarding the cue, re-asserting a symptomatic agenda, normalising it, or emphasising the patient's responsibility for the problem (Table 2). Engagement included closed questions about the nature of the experience, but also counselling to explore the patient's difficulties (Table 2). GPs generally closed such discussion by proposing symptomatic intervention or follow-up:

P: 'Yes, it's a terrible feeling inside, I feel rotten inside for some reason I don't know why.'

Dr: 'Well let's see you in a fortnight and see if you've shaken it.'

Linking psychosocial problems and explanation for symptoms

GPs only rarely linked psychosocial problems with explanation of the patient's symptoms. Indeed, some made separation explicit:

'Well I think there's two things, let's be clear, there's your mood and how close to depression that you feel and there's also, and your chest and there's two things that we need to run along in parallel.'

However, one asked if 'some of your health concerns stem from the pressures', and three others incorporated emotional mechanisms into explanations (for example, in explaining skin problems, 'you sweat more if you're stressed'). Three patients also spontaneously attributed their symptoms to stress, 'nerves' or depression.

Discussion

Summary of main findings

The view that many patients with unexplained symptoms insist on symptomatic solutions and exclude psychological needs from consultation has been supported by theoretical arguments,⁷ and by GPs' subjective reactions to such patients, including the use of the term 'heart-sink',¹⁶ powerlessness,¹⁷ and feeling pressured for symptomatic

Table 2. Ways in which GPs responded to psychosocial opportunities.

Reassert a somatic agenda	<p>P: 'It was ... just like depression, just sitting there and crying for no reason at all.'</p> <p>Dr: 'OK, well do you want to wait until we get the bone density back and we'll know where we are or do you want to say let's go for something now?'</p>
Normalise the problem	<p>P: 'Oh dear. Have I got to have any more, any more? After me wife died I had both my knees, done. My second knee was done in February '97, in February '98 I had that appendix and December '99 I had this flu. I shouldn't have had it after I had the injection should I?'</p> <p>Dr: 'It's bad luck isn't it?'</p>
Locate responsibility with the patient	<p>P: 'I'm still drinking a fair amount. As I say it's living in the place where I am, I'm living on my nerves, people busting the door in you know ... I live on the middle floor, only got one room. The social worker 'phoned the housing [department] up the other day, try and get me a place.'</p> <p>Dr: 'Yes, yes it would be better wouldn't it if you moved out of there.'</p> <p>P: '... All I want to do is sleep all the time. It's hard to try and get off the drink on your own though, you do need help.'</p> <p>Dr: 'Have you tried Alcoholics Anonymous?'</p>
Counsel	<p>P: 'I let like small things like really bother me ...'</p> <p>Dr: 'Do you think there's anything that you're really angry about ... Is there anything upsetting you that you perhaps push away and that's why it comes out in these other ways?'</p> <p>P: 'I never thought about that ... It could be something that it's bringing it out this way like you know.'</p> <p>Dr: 'Nothing sort of springs to mind?'</p> <p>P: [Disclosure of previous affair] 'Sometimes her [wife's] behaviour towards me, maybe that's in a way sort of gets me going sometimes you know.'</p> <p>Dr: 'So you sort of go on the defensive?'</p>

responses.³ By contrast, in the present study we observed patients' presentation directly and found that almost all patients provided opportunities for doctors to address psychological issues.

Strengths and limitations of this study

As qualitative work in a restricted sample of patients and doctors, the present study can challenge existing assumptions about unexplained symptoms, but future, quantitative research should test the generalisability of the findings. Because of our decision to use the GP's assessment of whether or not patients' symptoms were unexplained, our results cannot be directly compared with studies which used external assessments of symptom causation. The proportion of recruited patients who had unexplained symptoms (about 10%) was lower than anticipated. Participating GPs commented that patients with unexplained symptoms were less likely than others to consent to audiotaping of consultations. Our results may therefore not adequately characterise the full range of interactions between these doctors and patients.

Relationship to existing literature

More than half the patients provided cues for the GP to explain their symptoms. Rather than firm beliefs about disease, cues indicated uncertainty and concern, and many proposed the absence of disease. Whereas patients provided evidence for their beliefs,⁶ doctors rarely provided 'evidence-based' responses. They disregarded many cues and, like hospital doctors,^{18,19} offered reassurance that failed to address patients' stated concerns, and neglected the anxiety elicited by negative test results or was contradicted by referral.

In general, patients evaluate doctors' explanations by comparing them with what they already believe and know,²⁰ and they seek explanations that embody a tangible mechanism to indicate that unexplained symptoms are accepted

as real.²¹ The responses that we observed were therefore unlikely to help patients. Moreover, some were counter productive: in responding to patients' cues for explanation by providing symptomatic treatments, investigations or referral, doctors effectively 'somatised' these patients. In addition, a separate analysis describes how ineffective explanation exacerbated patients' presentation.²²

Half of the patients also provided unambiguous cues to emotional or social problems. References to stress and external pressures were common, but so were explicit references to mood, including depression. Patients typically introduced these spontaneously during somatically focused discussion. Nevertheless, most doctors prevented their discussion, typically by reasserting the somatic agenda — which is how physicians also terminate 'empathic opportunities'.²³

Our findings are inconsistent with the view that, in primary care, a substantial group of patients with unexplained symptoms seeks to exclude psychological issues and is committed to somatic explanation. This view should therefore be re-examined. Around half of the patients with unexplained symptoms who were also psychologically distressed, had previously been categorised as believing in entirely physical causes for their symptoms,¹⁰ or as presenting solely somatic problems.²⁹ However, patients' beliefs, as expressed in our consultations (and in interviews⁶), were more sophisticated than the dualistic distinction between physical and psychological factors that these categorisations imply. For instance, many patients linked their symptoms to stress, a concept that combines physical and psychological dimensions.^{6,21} Moreover, our findings were consistent with recent evidence that, among primary care patients with unexplained symptoms, 'somatisers' are very similar sociodemographically, psychologically and medically to 'psychologists' and that, in many somatising patients, psychological problems are easily uncovered.²⁶

Implications for clinicians

Our data cannot show whether GPs should take the psychological opportunities that patients with unexplained symptoms offer. Theoretically, this should help: GPs think that psychological factors are important in understanding unexplained symptoms;³ primary care consultations, in which psychosocial cues were acknowledged, were shorter;¹¹ and clinical improvement in psychologically distressed patients is related to the therapeutic alliance with the GP,²⁷ to which acknowledging patients' psychological needs should contribute. In practice, however, disclosure has made no difference²⁸ and our doctors might have disregarded opportunities because they had no effective response.

Nevertheless, conventional treatment of persistent unexplained symptoms in primary care is ineffective and counter productive.¹⁰ Our findings at least indicate that patients present doctors with opportunities that are rarely tested. In particular, consistent with previous evidence,²⁹ few doctors used patients' psychosocial cues in providing the explanations that patients needed for their symptoms. The findings therefore have implications for the use of reattribution training by GPs.^{4,10,12} While its efficacy has been attributed to changing patients' beliefs about their symptoms, it might, instead, be a consequence of doctors' greater readiness to engage with the cues that patients already present.

Unanswered questions

Future attempts to improve the care of patients with unexplained symptoms will require an understanding of the factors that cause GPs to respond in the different ways that we have described, as well as evidence about whether the different responses lead to different treatment decisions. Our quantitative analysis of a larger sample of consultations will address these questions. Whereas there is already considerable interest in patients' unvoiced agendas in primary care,³⁰ more research is required into the importance of agendas that are voiced but apparently unheard.

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Supplementary information

Additional information accompanies this paper at:
<http://www.rcgp.org.uk/journal/index.asp>

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